CALIFORNIA DEPARTMENT OF
Mental Health

LTCS BEST PRACTICE CATALOG SUBMISSION COVER SHEET

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[ ] **CHANGE IN CONTACT INFORMATION**

Name: Jim Vess, PhD. Director Clinical Outcome Evaluation Services

Telephone Number: 805-468-2091

E-Mail Address: Jvess@dmhash.state.ca.us

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CALIFORNIA DEPARTMENT OF Mental Health

LTCS BEST PRACTICE CATALOG SUBMISSION

Project Title: **Clinical Outcome Evaluation Services.**

Function Category:

[X] **PATIENT-FOCUSED** [ ] **ORGANIZATION** [ ] **STRUCTURES**

Sub-category(s): Assessment of Patients

Heading: Initial and Continuing

Contact Person: Jim Vess, PhD. Director Clinical Outcome Evaluation Services

Telephone Number: 805-468-2091

Hospital: Atascadero State Hospital

The following items are available regarding this Best Practice:

☒ **Administrative Directive**
☒ **Update Report on COE**
☒ **Administrative Organizational Chart**

1. SELECTION OF PROJECT/PROCESS AREA (Describe how and why your team selected this project/process area for improvement.):

The purpose of the Clinical Outcome Evaluation System at ASH is to evaluate the results of patient care. Consisting of an organized set of measures, this system provides data with which to monitor ongoing clinical performance. This system focuses on three primary areas:

1)patient factors
2)treatment factors
3)post-hospital outcomes

It provides a mechanism to address the question of what types of patients, given what forms of treatment, demonstrate what kinds of outcomes.

2. UNDERSTANDING EXISTING CONDITION WHICH NEEDS IMPROVEMENT

(Describe the relationship of your project to your goals for improvement, and describe current process performance.):

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3. ANALYSIS **(Describe how the problem was analyzed.):**
The development of comprehensive outcome evaluation procedures began in 1994 with the design of a system to measure post-hospital outcomes and the creation of supporting instruments. By August 1994 data were being routinely collected on patient satisfaction, short term post-discharge adjustment, and long term recidivism. What remained to be developed was a mechanism for collecting data on patient and treatment variables for use in understanding patients' post-hospital outcomes.

In keeping with the facility's Biopsychosocial Rehabilitation approach to treatment, instruments to measure functional skills and psychiatric symptoms were necessary. A search was conducted to identify instruments useful in the evaluation of functional skills and symptoms in forensic psychiatric inpatients. Unfortunately, no instruments were found which met this need adequately in a way that led directly to treatment planning and outcome evaluation. Two measures were therefore developed at this facility, the Atascadero Skills Profile (ASP) and Psychiatric Medication Review Instrument (PMRI). The Atascadero Skills Profile was piloted on two treatment programs beginning June 7, 1995. It has been used hospitalwide since March 1, 1997. The Psychiatric Medication Review Instrument is used by psychiatrists at each 30 day medication review to rate various symptoms and prescribe appropriate medications. This instrument was implemented July 5, 1995.

In order to utilize standardized measures for the purposes of outcome evaluation, data must be consistently gathered and electronically available in aggregate databases. This function is served by a computer-assisted treatment planning process, whereby treatment teams routinely rate patient functioning in the process of assigning appropriate, dispositionally relevant treatment. These data are entered into a computer program to produce each patient's treatment plan, and are therefore also available for analysis in relation to other outcome measures.

A related development was the alignment of treatment activity protocols to the areas of the Atascadero Skills Profile (ASP). Prior to the implementation of the computer assisted treatment plan, there was no central organizing principal for the content of treatment activities. The activities provided across the various treatment units reflected the perceived needs of the patients, but also the variations in training, experience, theoretical orientation, and personal preferences of the disparate staff comprising the interdisciplinary teams. With the advent of the Atascadero Skills Profile, programs set about to identify each treatment activity as addressing discrete domains of skill functioning. This required the development of a standardized treatment activity protocol format in which the focus and goal of each activity was defined in terms of the areas of functioning specified by the Atascadero Skills Profile.

4. IMPLEMENTATION **(Describe your implementation of the solution.):**
The major task of clinical outcome evaluation is to assess the relationships between the measures of patient factors, treatment factors, and post-discharge functioning. Statistical procedures, including survival analysis, are applied to the data collected on patient factors and treatment factors to account for variations in post-hospital outcomes. In this way an empirical

understanding can be gained of the essential question as to what types of patients, given what forms of treatment, demonstrate what kinds of clinical outcomes.

In order to provide an integrated and comprehensive understanding of the complex relationships among patient factors, treatment factors, and post hospital outcomes, a centralized clinical outcome evaluation process is utilized.

Primary responsibility for this outcome evaluation process lies with the Director of Evaluation and Outcome Services (EOS), under the supervision of the Clinical Administrator. The Director of EOS ensures the applicability and compatibility of the various clinical measures used for outcome evaluation at ASH, as well as the integration of local procedures with the statewide outcome evaluation system currently under development. The staff of the Evaluation and Outcome Services perform centralized assessment and outcome evaluation functions.

Program Directors are responsible for the development, administration and reporting of specific pre-post group measures to evaluate specific treatment activities conducted within a program. The adequacy of assessment procedures conducted by each professional discipline is monitored by the discipline chief.

Responsibility for the collection of data on patient change over the course of hospitalization lies with the Program Directors. Program staff enter data from the ASP and PMRI into the Computer Assisted Treatment Planning (CATPA) database and the hospital patient tracking system.

Evaluation and Outcome Services staff are responsible for organizing data generated by the outcome measures on a quarterly basis.

Interpretation and application of outcome data for program evaluation is the responsibility of the Program Directors, with the assistance of the Director of Evaluation and Outcome Services, under the direction of the Clinical Administrator.

AREAS OF MEASUREMENT AND INSTRUMENTATION

There are three primary areas of measurement in the overall outcome evaluation system: patient factors, treatment factors, and post hospital outcomes.

PATIENT FACTORS. There are two basic segments of relevant patient factors. The first is patient characteristics that are essentially static and include such variables as commitment status, demographic variables (e.g. gender, age, etc.) and criminal and psychiatric history. These variables play an important role in mediating treatment outcomes, and are accessed through the Department of Mental Health's Admission, Discharge, and Transfer (ADT) database. The second segment is the assessment of patient needs. Needs are assessed using the following instruments:

Functional Skills: Atascadero Skills Profile (ASP). The ASP provides a standard evaluation of the primary psychosocial skills relevant to the treatment of our patient population. It measures a patient's initial level of skill in ten key domains of functioning and is first administered to all patients following admission. In subsequent Transfer, 60 and/or 90 Day treatment planning conferences, ASP data provide the baseline for monitoring patient response to treatment and as the basis for treatment planning to remediate those skill areas identified as the primary obstacles to discharge.

Psychiatric Symptoms: Psychotropic Medication Review Instrument (PMRI). Factors related to psychiatric symptoms that have been demonstrated to affect the adequacy of the post hospital adaptation include the severity, chronicity and persistence of symptoms despite treatment. Psychiatric symptoms are assessed initially by the admitting psychiatrist for the degree of functional impairment and subjective distress that they cause the patient as measured with the PMRI. These evaluations focus on the degree to which symptoms prove responsive to medication.

Psychopathy: HARE Psychopathy Checklist-Revised (PCL-R). Personality traits are assessed in terms of their impact on response to treatment and need for enhanced security. The degree of psychopathy is significant in the patient population and must be accounted for in clinical decisions about amenability to treatment and the nature of supervision required

Neurocognitive functioning: Neurocognitive Screening Battery. Neuropsychological and cognitive capacity are assessed in order to make effective treatment planning decisions, enabling treatment teams to place patients into treatment modalities which are best suited to the patient's cognitive strengths and weaknesses. Data on neurocognitive functioning are also necessary to accurately evaluate overall treatment outcome by controlling for variables anticipated to effect patient response to treatment. Therefore a neurocognitive screening is used to provide a baseline measure of neurocognitive functioning and to identify patients who require further evaluation of apparent neurocognitive deficits.

Sex Offender Characteristics: Sex Offender Assessment Battery. Sexual offenders committed under the Welfare & Institution Code are assessed with a variety of measures specific to their commitment. These assessments include but are not limited to the following: MMPI-2, MCMI-III, Multiphasic Sex Inventory II, EMPAT, Bumby Cognitive Distortions Scale, Psychosexual Life History, and penile plethysmograph.

<u>TREATMENT FACTORS</u>: Measures in this area focus on the amount and types of treatment provided as well as patient response to treatment during hospitalization. Specific measures include:

Number and Type of Planned Scheduled Treatment (PST) hours: Treatment Activities are designed to address specific areas of skill deficit. For example, treatment groups are directed towards identified skill deficits such as substance abuse, anger management, symptom

management, and medication management. The amount of treatment delivered in each of these specific areas is monitored using a treatment delivery database.

Pre and post treatment group measures: All treatment activities at ASH have specific treatment protocols which define goals and objectives in terms that can be empirically measured. Outcome data are collected using a standardized format to assess patient change related to each treatment activity by measuring patients' level of functioning prior to and again following completion of the activity sequence.

ASP change scores: The ASP is used to assess the nature and degree of change a patient demonstrates over the course of his treatment at ASH. This measure is used for ongoing treatment planning, to assess readiness for discharge, and to assess a patient's overall response to hospitalization for outcome evaluation purposes.

Post-Hospital Outcomes: The primary goal of treatment is the patient's successful performance in the post-discharge environment. Therefore a separate set of measures that reflect post-discharge functioning is essential to outcome evaluation. These measures assess the patient's ability to manage symptoms and apply skills acquired during hospitalization.

PATIENT SATISFACTION:
Patient Evaluation Form. Staff from the Admission Suite are responsible for soliciting responses on this self report instrument which is completed by patients at the time of their discharge. The measure allows patients to provide feedback on the adequacy of treatment from their perspective.

Short term post-discharge functioning: Post-Hospital Inventory. This measure consists of a structured telephone interview completed by staff of Evaluation and Outcome Services three months after the time of discharge. The information gathered includes patient functioning in the areas of managing symptoms, compliance with medication, treatment compliance, assaultiveness, substance abuse, activities of daily living, work and school.

Rehospitalization and Recidivism: Access to data collected on discharged patients allows the hospital to determine patient outcomes in terms of recidivism and re-hospitalization. Data is requested from the Department of Justice, in the form of Criminal Identification and Information (CI&I) reports, for samples of patients who have been discharged from ASH for three years. This information is supplemented by data from the Admission, Discharge, Transfer database (ADT) maintained by the Department of Mental Health and the Offender Based Information System database (OBIS), maintained by the California Department of Corrections.

5. RESULTS (Demonstrate that an improvement has occurred as a result of the project/process area implementation.):

- The Atascadero Skills Profile has been found to be a psychometrically sound measure of functional skills, with over 20,000 administrations to more than 5,000 different patients. It is used for treatment planning, program development and outcome evaluation.

- By evaluating the matching of clinical service delivery to patient need as measured by the ASP, adjustments have been made to increase treatment activities in areas of skill functioning related to post-discharge success.
- Over 1,100 patients have been followed three months after discharge using the Post-Hospital Inventory, a structured telephone interview conducted with a service provider in the dispositional environment familiar with the patient's functioning. Results from this measure indicate that the most common factors in placement failure in the community include psychiatric decompensation, often with medication non-compliance, and substance abuse.
- There have been increases in treatment activities related to symptom management, depression management and anger/assault management skills. Over the same period, there has been a decrease in placement failures for the sample of patients discharged to CONREP as measured by the Post-Hospital Inventory.
- Results of the Post-Hospital Inventory indicate that patients discharged to CONREP have a much lower rate of rearrest than patients discharged to Parole, but a higher rate of rehospitalization (16%). It appears that patients discharged to Parole are rarely rehospitalized, but that 36% are reported as revoked or AWOL at the time of the three month follow-up.
- Data on recidivism at three years post-discharge continue to reflect a difference in outcome related to disposition, with patients discharged to CONREP showing higher rates of rehospitalization but lower rates of rearrest than patients discharged to parole.
- The findings from ASH databases are consistent with reports prepared by Dr. Mark Wiederanders and colleagues at DMH Headquarters. They report a rearrest rate of between 5% and 8% for patients during one year of community CONREP exposure, with an additional 20% returned to state hospitalization during that period.

6. LEARNING **(Describe what the team learned and how they used those lessons to continuously improve the success of this Best Practice.):**

The system of performance improvement based upon the measures described here is considered a work in progress. This process has thus far successfully implemented a set of measures which standardize data collection on patient functioning and post hospital adaptation. These data provide the basis for a much more uniform and explicit assessment and treatment planning process. It also provides current descriptions of the needs of the patient population in an aggregate manner. This in turn has allowed evaluation of the adequacy of treatment programs in terms of the amount and functional level of treatment activities provided to patients.

By gathering systematic post-hospital outcome data, there is now a means of determining the factors associated with successful patient adaptation in the discharge environment. This has confirmed the importance of certain basic skills, such as managing psychiatric symptoms and preventing substance abuse. In turn, there is now an increasing emphasis in these clinical areas, resulting in more focused treatment activities.

The process of gathering data from post hospital service providers has also highlighted the importance of sharing information to enhance continuity of care. This facility now has a source

for ongoing dialog about the adequacy of the preparation that patients have received, as well as information about the expectations of these aftercare providers. This information is provided to administration and program managers, so that adjustments in procedures can be made to better align services with the demands of the post discharge environment.

State Hospital Outcome Evaluation System (SHOES). A system is currently under development to provide standardized outcome evaluation data for all four of California's state hospitals. It will include measures of patient characteristics and level of functioning, measures of treatment, measures of post-hospital outcomes, including patient satisfaction, and measures of cost. This system is intended to provide information regarding the types of patients served by our state hospitals, the nature of the treatments provided, and the outcomes achieved for the funds expended. Various elements of this system are in the design and pilot stages, with the entire system expected to become operational over the next two to three years.